CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

November 5, 2001

H.R. 2768
Medicare Regulatory and Contracting Reform Act of 2001

As ordered reported by the House Committee on Ways and Means
on October 11, 2001

SUMMARY

The Medicare Regulatory and Contracting Reform Act of 2001 would require the Centers for Medicare and Medicaid Services (CMS) to modify how Medicare regulations and policies are developed, communicated, and enforced, and would modify the procedures used to resolve disputes involving payment for services covered by Medicare. The bill would transfer certain administrative law judges from the Social Security Administration (SSA) to the Department of Health and Human Services (HHS). It would change the procedures by which Medicare makes contracts with entities, and would place new requirements on those entities. It would require the Secretary of HHS to conduct several demonstrations, and would require the completion of several studies and reports.

Assuming the appropriation of the necessary funds, CBO estimates that implementing H.R. 2768 would cost $41 million in 2002 and $548 million over the 2002-2006 period.

The procedural changes required by H.R. 2768 would affect spending for services covered by Medicare, which is direct spending. However, many of the bill's requirements codify existing practices, while the other requirements would cause minor increases or decreases in spending for covered services. CBO estimates that the changes in direct spending would be insignificant. Because the bill would affect direct spending, pay-as-you-go procedures would apply.

H.R. 2768 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The requirement for public hospitals participating in the Medicare program to comply with the bloodborne pathogens standard promulgated by the Occupational Safety and Health Administration (OSHA) would have cost implications for state and local governments. However, those requirements would be conditions of participating in a voluntary federal program and thus would not be intergovernmental mandates as defined in UMRA. H.R. 2768 contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

For this estimate, CBO assumes that the legislation would be enacted this fall and that estimated amounts would be appropriated each year. The costs of this legislation fall within budget function 570 (Medicare).

BASIS OF ESTIMATE

Table 1 shows the estimated authorization levels and outlays for Medicare administrative expenses under current law and under H.R. 2768. Assuming appropriation of the estimated amounts, CBO estimates that enacting H.R. 2768 would cost $41 million in 2002 and $548 million over the 2002-2006 period.

TABLE 1. ESTIMATED BUDGETARY IMPACT OF H.R. 2768

	By Fiscal Year, in Millions of Dollars					
	2001	2002	2003	2004	2005	2006
SPENDING SUBJECT TO APPROPRIATION						
Spending for Medicare Administrative Costs Under Current Law						
Estimated Budget Authority [a]	3,352	3,500	3,646	3,797	3,955	4,118
Estimated Outlays	3,267	3,464	3,631	3,757	3,913	4,074
Proposed Changes						
Estimated Authorization Level	0	46	125	134	126	130
Estimated Outlays	0	41	116	133	128	129
Spending for Medicare Administrative Costs Under H.R. 2768						
Estimated Authorization Level	3,352	3,546	3,771	3,931	4,081	4,248
Estimated Outlays	3,267	3,505	3,747	3,890	4,041	4,203

a. Budget authority for 2001 is the amount appropriated for that year.

Contracting Reform. Under current law, CMS contracts with fiscal intermediaries and carriers to process and pay claims, to educate providers regarding Medicare billing policy, and for other purposes. This bill would change both the method by which CMS enters into contracts and the activities required of contractors. CBO expects that these provisions would increase the cost of administering contracts, the total amount CMS spends on contracts, and spending by contractors on the education of providers about Medicare billing practices. We estimate the cost of implementing these provisions would be $14 million in 2002 and $336 million during the 2002-2006 period.

H.R. 2768 would direct CMS to provide incentives to contractors who meet or exceed certain performance standards. Based on information furnished by CMS, we estimate that the incentive payments would total 3 percent of operating payments to contractors, or about $233 million over the 2002-2006 period.

H.R. 2768 would require CMS to competitively bid contracts with fiscal intermediaries and carriers at least every five years. CBO expects that an additional 3-5 FTEs at the GS-12 level would be needed throughout the period to write new competitively-bid contracts. The estimate assumes that about one-quarter of the contracts would be awarded to a nonincumbent bidder, and that it would cost about $2 million to transition between contractors. CBO estimates that implementing this provision would cost about $54 million over the 2002-2006 period.

In addition, the bill would direct the Medicare program to measure the payment error rates for individual contractors, which are believed to indicate how well providers understand proper Medicare billing procedures, with the intent of identifying contractors who have achieved high levels of provider education. This provision would expand current practice, which is to calculate a contractor-wide error rate. The bill would also expand the requirement for contractors to monitor the accuracy of information given to providers, and would limit the liability of contractors for payment errors. CBO estimates that complying with these provisions would cost about $27 million over the 2002-2006 period.

The bill also would instruct contractors to tailor their educational efforts toward providers with staffs of fewer than 26 people, or physicians with fewer than 11 staff members. The bill would authorize the appropriation of $10 million in 2003 and in 2004 to provide additional educational services. CBO estimates that 80 percent of the authorized amount would be spent in the current fiscal year and 20 percent the year after.

Appeals and Claims Payment Reform. H.R. 2768 would change the processes by which Medicare pays claims and adjudicates appeals by providers of payment denials. CBO estimates that implementing these provisions would cost $9 million in 2002 and $104 million over the 2002-2006 period.

Resubmission of Claims. Under current law, providers may pursue payment for claims initially submitted to contractors with errors and omissions either via resubmission of claims in some instances or via the appeals process. H.R. 2768 would direct CMS to expand the instances in which providers may resubmit claims directly to contractors. CBO expects that this provision would lead to an increase in the number of incomplete claims submitted and a 1 percent increase in the number of claims processed. We estimate that processing those incomplete claims would increase costs by $5 million in 2002 and by $46 million over the 2002-2006 period.

Reliance on Guidance. H.R. 2768 would prohibit any sanction (including recoupment of overpayments) of a provider who relies on written guidance from contractors. CBO assumes this provision would increase the number of requests for written guidance by 50 percent. Under current law, contractors are required to respond to those requests. CBO estimates that the cost to contractors of issuing written responses to the additional requests, and the cost to CMS of oversight of those responses, would total less than $500,000 in 2002 and $29 million over the 2002-2006 period.

Standardization of Compliance Actions. The bill would also standardize existing policies regarding:

- Using random and non-random prepayment review,
- Using extrapolation after finding of overpayment,
- Enrolling providers and adjudicating appeals of enrollment denials,
- Communicating findings of overpayment to providers,
- Notifying providers regarding billing codes that the contractor suspects are being overused,
- Requiring providers to act within 45 days during the consent settlement process, and
- Collecting overpayments from providers.

CBO estimates that implementing those provisions would cost $28 million over the 2002-2006 period.

Appeals Reform. H.R. 2768 would modify the current appeals system. The bill would allow appellants to petition review boards for expedited access to judicial review outside of the Medicare review system. The bill would also require appellants to present all relevant evidence at the reconsideration level. These provisions are estimated to reduce

administrative outlays by about $6 million over the 2002-2006 period because they are expected to reduce the caseload at the third and fourth level of appeals.

The bill would transfer certain administrative law judges (ALJs) from the Social Security Administration to the Department of Health and Human Services. CBO estimates that the costs of planning and implementing the transfer, and providing the ALJs with additional training on Medicare issues, would total $8 million over the 2002-2006 period.

These provisions would require CMS to make changes to current appeals and compliance systems but would not change the conditions under which Medicare would make payments to providers. Therefore, CBO estimates that these provisions would have no effect on direct spending.

Demonstrations and New Program Areas. H.R. 2768 would direct CMS to expand its programs to educate beneficiaries and providers. CBO estimates that implementing these provisions would cost $9 million in 2002 and $69 million during the 2002-2006 period.

The bill would create a demonstration project for the provision of technical services to small providers. Participating providers would receive education specifically related to their practice, as well as information about general Medicare billing and documentation requirements. Participants would contribute 25 percent of the costs of the technical assistance. The bill would authorize the appropriation of $1 million in 2003 and $6 million in 2004 for the demonstration.

The bill would also direct CMS to implement a three-year outreach demonstration in at least six locations throughout the United States. The program would involve the deployment of Medicare specialists to local Social Security Administration offices to provide beneficiaries assistance and advice regarding the Medicare program. CBO estimates that the costs of the demonstration, which would include the rental of office space, salaries for Medicare specialists, and travel, moving, and administrative expenses, would total $4 million over the 2002-2006 period.

H.R. 2768 would require CMS to develop two new ombudsman offices, for providers and beneficiaries, within the Medicare program. Each office would act as a liaison between either providers or beneficiaries and the agency. The offices would be responsible for offering advice and assistance to individuals regarding the program, as well as conveying the concerns of providers and beneficiaries to program officials. The bill would authorize such sums as may be necessary in 2002 and thereafter for these ombudsman offices. CBO estimates that the number of staff required to perform these functions would grow from 85 FTEs in 2002 to 155 FTEs in 2006. We estimate these ombudsman activities would cost $54 million over the 2002-2006 period.

H.R. 2768 would also require CMS to establish a Council for Technology and Innovation within CMS. The Secretary would appoint an Executive Coordinator for the council. CBO estimates that CMS would spend about $1 million a year to staff and operate the Council for Technology and Innovation.

Development of Policies, Procedures, and Time Lines. H.R. 2768 would require CMS to develop new policies, procedures, and time lines with regard to the issuance of regulations, documentation guidelines for evaluation and management services, and the Medicare Secondary Payer program. CBO estimates the cost of implementing these provisions would be $9 million in 2002 and $36 million during the 2002-2006 period.

Final Regulations. The bill would require CMS to create a time line for the publication of final regulations and limit publication of new regulations to once a month. There currently are 22 "interim final rules;" the bill would require CMS to make those rules final, and would require CMS to finalize all future regulations.

CBO estimates that it would cost about $9 million in 2002 to finalize existing interim final rules. We estimate that CMS would need to hire an additional 3 to 5 staff, at the GS-11 level or higher, and spend an additional $10 million through 2006 to comply with the requirement to finalize all future interim regulations and to produce the required reports.

Documentation Guidelines for Evaluation and Management (E&M) Services. H.R. 2768 would restrict CMS from implementing new documentation guidelines for evaluation and management services until several conditions have been met. Those conditions include:

- Establishing plans to improve the guidelines,
- Completing pilot projects to test modifications to the guidelines,
- Educating providers about the guidelines, and
- Consulting providers during the entire process of testing and establishing the guidelines.

CMS currently has E&M guidelines in place, and the bill would not require changes in those guidelines. CBO assumes that CMS will attempt to update those guidelines during the next few years, because both CMS and provider groups have expressed interest in doing so. The new procedural requirements would increase the cost of developing and implementing new E&M guidelines. Establishing new guidelines for E&M documentation would require the hiring of at least two FTEs for the administration of the pilot projects, for outreach to providers, and for consultation with providers. CBO further estimates that CMS would conduct at least three pilot projects, with each project costing around $1 million per year, and that the studies and reports required by these provisions would cost another $1 million.

Medicare Secondary Payer program. The Medicare Secondary Payer program requires providers and suppliers to collect insurance information from beneficiaries to determine whether Medicare will be the secondary payer on a claim. The bill would restrict Medicare from implementing special requirements for hospital-based laboratories that act as referral laboratories, with respect to gathering insurance information from patients, unless independent laboratories are also required to collect such information. Under current policy, referral laboratories, which conduct tests without direct contact with patients, would have to begin gathering this information beginning in January 2002. CBO estimates that the costs of complying with this provision would be negligible.

Medicare Coverage Policies. H.R. 2768 would change the timing of CMS's national coverage decisions concerning certain new technologies. Upon request by an applicant, the Secretary would be required, to the extent feasible, to coordinate reviews of coverage decisions with the review for premarket approval conducted by the Food and Drug Administration. H.R. 2768 would require the Secretary to submit to the Congress a plan for achieving such coordination within six months. CBO estimates that establishing and operating the coordination process would cost $1 million in 2002 and $3 million over the 2002-2006 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. CBO estimates that the bill would not affect receipts and would have no significant effect on direct spending.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 2768 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act. The requirement for public hospitals participating in the Medicare program to comply with OSHA's bloodborne pathogens standard would have cost implications for state and local governments. The current OSHA standard applies to all private-sector employers with one or more employees, as well as to federal civilian employees. This bill would extend the requirement to all hospitals participating in the Medicare program, including state and local public hospitals. About half of the states currently have bloodborne pathogen standards that apply to these hospitals that are at least as stringent as the federal standard. Public hospitals in the remaining states could face additional costs as a result of the new requirement. Those costs, however, would result from participating in Medicare, a voluntary federal program, and thus would not be costs of an intergovernmental mandate as defined in UMRA.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

H.R. 2768 contains no private-sector mandates as defined in UMRA.

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